Oncology

Rx International Pharmacy

Phone: (305) 221-1421
Fax: (305) 221-3275

Patient information

Patient Name: _____ DOB: _____
Sex: ❑ Female ❑ Male SS #: _____
1˚ Language: _____ Wt:_____ ❑kg ❑lbs Ht:_____❑cm ❑in
Address: _____
Apt/Suite: _____ City:_____ State:_____ Zip:_____
Phone:_____ Alternate Phone:_____
Caregiver name: _____ Relation: _____
Local Pharmacy: _____ Phone: _____
Insurance Plan: _____ Plan ID # _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + shipping information

Prescriber Name:_____
NPI #: _____
Address: _____
Apt/Suite #_____ City:_____ State:_____ Zip:_____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email address: _____
If shipping to prescriber: ❑ 1st Month ❑ Always ❑ Never

Clinical information (Please fax all pertinent clinical and lab information)

Diagnosis/ICD-10 (C00-D49): _____
Patient Type (if applicable):
❑ adult female NOT of reproductive potential ❑ child female NOT of reproductive potential
❑ adult female of reproductive potential ❑ child female of reproductive potential
Date: _____
BRAF mutation present (if applicable): ❑ V600E ❑ V600K Any prior treatment: ❑ No ❑ Yes (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____
Concomitant Medications: _____
Allergies: ❑ NKDA ❑ Other: _____

Prescription

❑ Cotellic™ Three 20 mg tablets (60 mg) for 21 days on, 7 days off
Quantity: 63 tablets Refills: _____

❑ Zelboraf® Four 240 mg tablets (960 mg) every 12 hours
Quantity: 240 tablets Refills: _____

❑ Lonsurf® ❑ 15 mg/6.14 mg Quantity: _____ Refills: _____
❑ 20 mg/8.19 mg Quantity: _____ Refills: _____

Take _____ mg (35 mg/m^2/dose) twice daily on days 1 through 5 and 8 through 12 for each 28-day cycle within one hour of completion of morning and evening meals (round to the closest 5 mg).

❑ Ibrance® ❑ 100 mg tablet with food for 21 days on, 7 days off
❑ 125 mg tablet with food for 21 days on, 7 days off
Quantity: 21 tablets Refills: _____
with letrozole daily. One 2.5 mg tablet once
Quantity: 28 tablets Refills: _____

❑ Ninlaro® One 4 mg cap daily on days 1, 8 and 15 of a 28-day cycle
Quantity: 3 capsules Refills: _____

❑ Revlimid®* One 25 mg cap for 21 days on, 7 days off
Quantity: 21 capsules Refills: _____

❑dexamethasone One 40 mg cap daily on days 1, 8,15 and 22 of a 28-day cycle
Quantity: 4 capsules Refills: _____

❑ Zytiga® Four 250 mg tablets (1000 mg) once daily without food
Quantity: 120 tablets Refills: _____
with prednisone One 5 mg twice daily with food
Quantity: 60 tablets Refills: _____

❑ Afinitor®	❑ Exjade®*	❑ Inlyta®	❑ Odomzo®	❑ Sylatron®	❑ Temodar®	❑ Xtandi®
❑ Afinitor® Disperz	❑ Farydak®	❑ Iressa®	❑ Pomalyst®**	❑ Tafinlar®	❑ Thalomid®**	❑ Zelboraf®
❑ Arimedex®	❑ Femara®	❑ Jadenu®	❑ Revlimid®**	❑ Tagrisso™	❑ Tykerb®	❑ Zolinza®
❑ Bosulif®	❑ Gleevec®	❑ Jakafi®	❑ Sprycel®	❑ Tamoxifen®	❑ Votrient®	❑ Zykadia™
❑ Cometriq®	❑ Hycamtin®	❑ Mekinist®	❑ Sutent®	❑ Tarceva®	❑ Xalkori®	❑ Zydelig™
❑ Erivedge®	❑ Imbruvica™	❑ Nexavar®	❑ Stivarga®	❑ Tasigna®	❑ Xeloda®	❑ _____

Strength(s): _____ Directions: _____
_____
Quantity: _____ Refills: _____ **Authorization: _____
Packaging: ❑ Normal

Exjade® Prescriptions (Fax ALL EPASS forms to 305.221.3275)

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Prescriber's Signature:_____ Date: _____
I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.